UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA

SYLVIA ALLEN,	)	Case No.
	)	01-4319-CIV-KING
Plaintiff,	)	
	)	
-v-	)	
	)	
R.J. REYNOLDS TOBACCO COMPANY, and PHILIP MORRIS, INC.	)	
Defendant.	)	Miami, Florida
	)	February 21, 2003
_____	)	Afternoon Session

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TRANSCRIPT OF JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE JAMES LAWRENCE KING
U.S. DISTRICT JUDGE

Appearances:

FOR THE PLAINTIFF:	Neal A. Roth, ESQ., OF: Grossman and Roth Penthouse One - Grand Bay Plaza 2665 South Bayshore Drive Miami, FL 33133
FOR THE PLAINTIFF:	Stuart Grossman, ESQ., OF: Grossman and Roth Penthouse One - Grand Bay Plaza 2665 South Bayshore Drive Miami, FL 33133
Reporter (561)651-3865	Stephen W. Franklin, RMR, CRR Official Court Reporter 701 Clematis Street, Suite 417 West Palm Beach, Florida 33401

APPEARANCES (CONT.):

FOR THE PLAINTIFF:	Andrew B. Yaffa, ESQ., OF: Grossman and Roth Penthouse One - Grand Bay Plaza 2665 South Bayshore Drive Miami, Fl 33133
FOR THE PLAINTIFF:	Jay Cohen, ESQ., OF: Grossman and Roth Penthouse One - Grand Bay Plaza 2665 South Bayshore Drive Miami, FL 33133
FOR DFT. RJ REYNOLDS	Benjamine Reid, ESQ., OF: Carlton Fields International Place, Suite 4000 100 S.E. Second Street Miami, FL 33131-9101
FOR DFT. RJ REYNOLDS	Gregory M. Cesarano, ESQ., OF: Carlton Fields International Place, Suite 4000 100 S.E. Second Street Miami, FL 33131-9101
FOR DFT. RJ REYNOLDS	Amy Furness, ESQ., OF: Carlton Fields International Place, Suite 4000

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		100 S.E. Second Street
		Miami, FL 33131-9101
	FOR DFT. RJ REYNOLDS	Ryan E. Harden, ESQ., OF:
		Jones, Day, Reavis & Pogue
		3500 Suntrust Plaza
		303 Peachtree Street
		Atlanta, GA 30308-3242
	FOR DFT. PHILIP MORRIS	Norman A. Coll, ESQ., OF:
		Shook, Hardy & Bacon, LLP
		Miami Center, Suite 2400
		201 South Biscayne Blvd.
		Miami, FL 33131-4332

APPEARANCES (CONT.):

	FOR DFT PHILIP MORRIS	Kenneth J. Reilly, ESQ., OF:
		Shook, Hardy & Bacon, LLP
		Miami Center, Suite 2400
		201 South Biscayne Blvd.
		Miami, FL 33131-4332
	FOR DFT PHILIP MORRIS	Stacey A. Koch, ESQ., OF:
		Shook, Hardy & Bacon, LLP
		Miami Center, Suite 2400
		201 South Biscayne Blvd.
		Miami, FL 33131-4332

(Call to the order of the Court.)

THE COURT: Bring the jury, please.

(The jury enters the courtroom, after which the following proceedings were had:)

THE COURT: Thank you. Be seated please.

All right. Mr. Reilly, your next witness, please.

MR. REILLY: Your Honor, I would call Dr. Steven Deprima.

THE COURT: Okay.

(The witness is sworn.)

THE COURTROOM DEPUTY: If you would state your full name, spelling your last name, please.

THE WITNESS: Steven Joseph Deprima.

THE COURTROOM DEPUTY: Spell your last name.

THE WITNESS: D-E-P-R-I-M-A.

Steven Joseph Deprima, Defense witness, sworn.

Direct Examination

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BY MR. REILLY:
Q Doctor, would you please tell the jury your name. You just did it, but if you would.
A Steven Deprima.
Q And you're a medical doctor?
A Yes, sir.
Q Can you tell the jury what kind of medical doctor you are?

A Yes, I'm a radiologist.
Q Do you practice here in town?
A Yes, sir, I do.
Q Where do you practice?
A I practice in Doctor's Hospital, in Coral Gables.
Q Could you give the jury an explanation of what is the medical specialty of radiology?
A Yes. It's involved with taking pictures of the human body. Medical technology has gotten to the point you can take some pretty sophisticate pictures of the human body. It's not simply an x-ray, like when you go to the emergency room with a broken arm anymore. There is just a ton of ways to take pictures of the human body. And we are the doctors that specialize in the reading of those pictures.
Q Okay. Doctor, have you ever testified at trial before?
A No, sir.
Q Okay. Doctor, can you tell me whether or not radiologists interpret plain films?
A Yes, they do.
Q And I've used that word, but now would you tell the jury what a plain film is.
A Yeah, a plain film is very -- I'm sure most people have been to the emergency room with either themselves or their kids with a broken arm and you get this flat piece of film, and they put it up on a light box and they tell you if your

arm is broken or not. That's a plain film. It's very similar to a picture you would take with a camera. You take a three dimensional human body, or whatever part you're looking at, and you reduce it to a single picture, just like a -- you take a picture of your family picnic, and that's a three dimensional picture. And then you have a picture from your Instamatic Kodak camera that represents the party.
Q Okay. Do you -- as a radiologist, do you also interpret CT scans? And I know I use the abbreviated term, CT.
A Yes, sir.
Q What are CT scans?
A Well, that's getting more sophisticated in terms of picture taking. Instead of looking at a three dimensional body in one dimension, like an Instamatic Kodak picture, a CT is a way to use x-rays again to take a two dimensional picture of the body. So you're beginning to get much, much better anatomy, and you can see things more clearly as a result of that.
Q In a little bit I'm going to have a homemade kind of demonstration for you to explain what a CT scan does. But let me just ask you some general questions before we get into that.
Do you also -- do radiologists also interpret Magnetic Resonance Images?
A Yes, sir, they do.

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Q Or MRI?
A Yes, we do.
Q Can you explain to the jury what that is?
A Well, it also involves the use of computers to take a picture. But instead of using radiation, people now are realizing radiation is maybe not the safest thing to do. MRI, or Magnetic Resonance, uses actually magnetism and sound waves to take pictures of the human body, just like you would use x-rays to take pictures, or we use light in the room to take an Instamatic picture. We use actually magnetism and sound waves.
Q Do radiologists also interpret sonograms, or I think another word for that is ultrasound?
A Yes, we do.
Q Can you once again -- my demonstrative just fell over.
A Yeah, ultrasound is the use of sound waves to take pictures of the human body. You can hook sound waves to a computer, and it's much like sonar looking at the bottom of the ocean floor. And I'm sure most people have seen ultrasounds with baby pictures when you're pregnant you go for a sonogram. And, again, radiation is maybe a little dangerous in some -- in some excessive amounts, so ultrasounds or sound waves are very safe for a fetus. And that's how we've come to -- that's the preferred way to image or take pictures of unborn children, fetuses.

Q Doctor, let's cover your medical educational background, and then we'll go into your personal experience as a physician. Could we start with where you went to medical school?
A Yes. I went to Emery University, in Atlanta, Georgia.
Q And what year did you graduate from medical school?
A I graduated in 1981.
Q Okay. And what did you do after graduating from medical school?
A I did a year internship in general surgery in the U.S. Air Force, and followed by a three-year residency in diagnostic radiology, also in the Air Force.
Q And where were you stationed in the Air Force?
A Travis Air Force Base, outside of Sacramento, California.
Q You said the term "diagnostic radiology". What is that?
A It's the medical specialty involving taking pictures of the human body, either normal or diseased, and interpreting those images.
Q You said your residency in diagnostic radiology was three years long. What do you do during your residency?
A Well, doctoring is a lot of book learning, but it's also a lot of O.J.T. You have to do it to learn how to do it.
And so early on in your training you have your teacher, or your mentor, by your side constantly. And then

as you become more and more experienced and capable in radiology, he lets you do more and more on your own, always checking your work. So that by the end of the training program, you're pretty much on your own. You have to run it by him, but you're doing it.
Q After you completed your residency -- what year did you complete your residency?
A '85.

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Q And after you completed your residency, what did you do?
A Well, I went into -- I was on active duty for four years in Eglin Air Force Base, here in the panhandle of Florida, as a diagnostic radiology at Eglin Medical Center, which is one of I believe it's five medical centers in the Air Force.
Q Okay. And how long were you -- you were practicing, then, as a diagnostic radiologist?
A Yes, sir.
Q And you did that for four years?
A Four years.
Q All right. What rank did you achieve in the Air Force?
A I made it to major.
Q Okay. Doctor, you are as soft spoken as I am, so we both probably need to speak up a little bit.
What did you do after you got out of the Air Force?
A I was in private practice for three years in Savannah, Georgia.

Q Okay. Practicing radiology?
A Diagnostic radiology.
Q All right. And that would have taken us up to 1980 --
A '92.
Q '92.
A '89 to '92.
Q Then what did you do?
A I pursued additional training in neuroradiology and interventional neuroradiology. So I did an additional fellowship at this time.
Q Can you explain to the jury what is neuroradiology?
A Yeah, simply, it's brain and spine.
Things have gotten so sophisticate in all of medicine you don't have just a general surgeon, you have a vascular surgeon. You don't have a general surgeon, you have a cardiothoracic surgeon. Radiology is doing that in a couple of areas, too. And brain and spine is one of them, and that's called neuroradiology.
Q Fellowships, are they hard to get?
A They're competitive, yes, sir.
Q How long was your fellowship?
A It was two years.
Q All right. And you completed that in 1994?
A '4, yes.
Q And then what did you do?

A I went to Doctor's Hospital, in Coral Gables, where I practiced it.
Q What is interventional neuroradiology?
A That's an offshoot of neuroradiology. Technology has really changed medicine a lot, and interventional neuroradiology is the -- one of the products of that technology. It turns out that you can treat a brain aneurism through the artery in the groin, as opposed to the old days where you had to actually remove bone and clip or fix the aneurism. And that's something that I did training in, and I can actually treat an aneurism using a catheter from the groin.
Q Okay. And you've been practicing general radiology and neuroradiology at Doctor's Hospital?
A Yes, sir.
Q Ever since?
A Yes.

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Q And, doctor, are you board certified?
A Yes, I am.
Q And who issues your board certification, and what does that mean?
A Well, it's issued by the American Board of Radiology. Most areas of medicine have their own board. It's a national organization administered by doctors and for doctors. And so our board would be the American Board of Radiology, and it's

recognized by the American medical society.
And as a way to insure quality and adequate training, you have to sit for an exam to be board certified. You could be a radiologist and not be board certified. The State doesn't require it. But it's just an additional level of competency. You have to sit for a written test, and if you pass the written test then at least in radiology we all go to Louisville, Kentucky, and have oral examinations that last a half a day.
Q And do you have a special certificate? You have a board certification in radiology. Do you have a special certificate in neuroradiology?
A That's right. As a result of that fellowship training, I was eligible to do pretty much the same thing in neuroradiology, and specifically brain and spine. There's no written part, you had to go to Louisville yet again and sit for an oral examination. And if you pass it, you got your CAQ, or Certificate of Additional Qualification.
Q Doctor, can you tell us whether you have any academic appointments.
A Yes, I'm an Assistant Clinical Professor of Radiology at the university, here at the University of Miami.
Q And what does that mean? What do you do?
A Teaching fellows in residence, predominantly. Conferences, grand rounds, noon -- they call it nooners. I

guess it's -- we don't get lunch in academics. That's always an excuse to sit down and do more education. So that's called nooners.
Q Okay. Doctor, can you tell us whether or not you have published in the field of radiology?
A Yes, I have.
Q And can you tell the jury about that?
A Well, I've published several articles in peer review journals that involve doing some sort of original research of your choosing. You write up -- you write your paper, you submit it to one of our national journals, and they have a editorial board that evaluates the article and deems whether it's worth publishing or not.
Q Doctor, can you tell this jury whether or not you've given presentations at conferences and symposium for colleagues of yours that are also radiologists and neuroradiologists?
A Yes, I have.
Q Can you tell the jury just a little bit about that?
A Well, it kind of pops up here and there throughout your career. But in particular, there is a neuroradiology conference out in the west that I've attended several times and presented.
I've been invited early when I was in Savannah to speak to the Georgia Medical Society in a little focus

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session. Various invitations.
Q Doctor, you indicated that you've never testified at trial before. Medical/legal work like you're doing right here, how much of your day is spent doing that?
A Just minimal. This is just not -- I'm a radiologist. I don't do this very much at all.
Q All right. Are you being compensated for being here today?
A Yes, I am.
Q And what is your hourly rate?
A $350 an hour.
Q All right. And how did you choose that dollar amount?
A Well, that kind of covers the practice. When I'm here I'm not reading x-rays at work. And there's still -- so I'm not making money as a doctor. I don't have anybody backing me up. So that kind of covers the ongoing business of making a living.
MR. REILLY: Your Honor, I would tender Dr. Deprima as an expert in radiology and neuroradiology.
MR. COHEN: I have no objection.
THE COURT: He is so certified, so designated.
You understand, ladies and gentlemen, he can express opinions.
Go ahead.
MR. REILLY: Thank you, Your Honor.

BY MR. REILLY:
Q Dr. Deprima, we contacted you and asked you to take a look at the radiology in Mr. Allen's case; is that correct?
A Yes, sir.
Q And did you do that?
A I did.
Q Can you tell the jury how you went about looking at Mr. Allen's radiology?
A Well, I was given a large number of x-rays, and they were arranged in chronological order. And so this is a series of x-rays over the last more or less year of Mr. Allen's life. And I was just asked to go through those x-rays and formulate an opinion. And that's what I did.
Q Okay. You say the x-rays. That included CT scans?
A Yes, sir.
Q Magnetic Resonance Image?
A Yes.
Q And sonogram ultrasound?
A Yes.
Q And did it -- CT scans, sonogram, MRI, taken at lots of different hospitals of Mr. Allen?
A Yeah, there were at least three hospitals. And if you considered the university in Jacksonville as separate entities, which they actually are, there were even more institutions.

Q Okay. Now, radiologists, when Mr. Allen was being taken care of, looked at those images initially, correct?
A Yes, sir.
Q Was there a consistency of the readers? In other words, was there a consistency of the doctors who were looking at these CT scans, sonogram, MRI?
A No, there wasn't. As you can imagine, if you go to South Miami Hospital there would be a different set of

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radiologists that would read your x-ray as opposed to the University of Miami. So since he went to different places, in fact, he was seen -- or the x-rays were read or interpreted by different radiologists.
Q But you had an opportunity to look at them all?
A Yes.
Q All together?
A Yes, I did.
Q All right. And, doctor, can you tell the jury whether or not you looked at the radiology reports that were prepared by the radiologists who were interpreting the CT scans, MRI, sonogram, if you looked at those?
A I did after I had looked at the x-rays. I looked at the x-rays first, and then I looked at the reports.
Q Why did you do it that way?
A That's how radiologists work. I mean, I was told to treat it as if this was a fresh case. So when you're at

work, that's exactly what you do. You're presented with an x-ray, or a set of pictures, you look at it, you formulate an opinion. There's no report. I mean, you're the guy that generates the report.
Q All right. Did you look at all the medical records, all the treating records and all that sort of thing?
A No, sir, I did not.
Q Do radiologists do that?
A No, we don't.
Q So in your normal practice you wouldn't do that?
A No.
Q All right. Doctor, can you tell us based upon your review of the films whether or not you'd agree that Mr. Allen had cancer?
A Yes, I would.
Q And how can you tell that, very briefly? We will get into the CT scans in just a minute.
A Things progressed in group. Everything that you identified early on got bigger over time. A few things became many things. It just progressed.
Q All right. Doctor, what role does the radiologist play in a patient's diagnosis of their condition?
A Well, he's a team player. I mean, as you can imagine, everything you can do in medicine gets a picture of it. We don't do exploratory surgery anymore, it often comes through

an x-ray. So the radiologist is the guy or the woman that sees the pictures and offers a radiologic impression or a radiologic diagnosis, if you will.
Q All right. Goes into the total package of everything that's being done about the patient?
A That's right. It's just a piece of the puzzle.
Q But you develop definite ideas about what you think's going on?
A Yes, sir.
Q Can you very briefly explain to this jury how, in the ordinary course of a radiologist's practice, you get called into a case and what you ordinarily get and what you do?
A Well, you typically have a place of work. And as x-rays or MRIs or CTs are ordered, they're typically -- in my practice they're placed with the patient's other films, if he's got it, called his master jacket. And then those are brought to you for interpretation. Actually, now things are

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doing -- going more and more to computers. So the days of actually holding up a film and offering a diagnosis are on their way out, and we're sitting with a mouse and a computer screen more and more, which is a different way.
Q When you look at films, what is it that the radiologist calls the interpretation they make?
A Conclusion, impression, report. I like impression.
Q And what are you conveying with the impressions that you

arrive at and communicate to the referring physician?
A Our impression, or my impression is my radiologic diagnosis. As you can imagine, things -- we're trained to look at these things. And after you've been looking at x-rays for a period of time, there are characteristic patterns of pictures you can see. And you can offer that up as it is your best professional opinion of what's going on with the patient based on the pictures you have.
Q And what is it -- this jury has seen some radiology reports, and they have already heard from a radiologist who's testified in the case. Can you tell us what it is that a radiologist ought to be reporting within the body of their report? What are you supposed to put in there?
A Well, the quick answer is things that are important. But as it turns out, we often do not have a lot of history. I mean, in a perfect world you get a phone call, you would have a very complete history. But in general, the amount of history we get as radiologists is pretty thin or nonexistent. So oftentimes you really should put most things that are abnormal in a report, and then you distill it down to its essence in that impression.
Q All right. Doctor, I'm now going to use my homemade demonstrative here and ask you if you would step down. And I'm going to give you a microphone, if I can find it.
I don't know whether you want it with the tie on or

off.
A I thought that I'd do something to show how CAT scans work, because we talk about slices and cuts and stuff like that. So the analogy that I wanted to use was that taking a CAT scan of somebody is like slicing a loaf of bread. We can take an x-ray of the whole chest or the whole abdomen, but that's a one dimensional picture. So if you could somehow lay the patient on his back and then take slices through the body part that you want, be it the chest or the abdomen, it would be like slices of bread.
So you have to bear with me here, because what I wanted to show was how this technique can show or not show things.
First of all, did you take a CAT scan of the right body part or not? If you ask for a chest and the abdomen is down where Mr. Reilly is, you may not image it. If you are looking at something -- let's say the loaf of the bread is the chest, and you want to look at it. You can take thicker or thinner slices. And the thinner of the slice the more anatomic detail you're going to get.
So you -- so in a CAT scan, the patient is laying on his back, and we almost slice the body with the computer. We actually slice the body into little slices so that when you open it up you can see a pulmonary nodular knot. Now, if you slice -- or mass.

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If you slice through the top of a mass it might look smaller, but that same mass can look bigger when you get to the middle of it. And then as you get to the bottom of the mass, bigger, it begins to become smaller or it disappears. So where you take your slice through a body part will change how it looks. Okay? If it's through the middle, the top, or the bottom, it will look different on these slices.

And you can imagine if you took a big enough slice you might miss the whole thing. You took too thick a slice to see the small abnormality.

Q That's not mold, is it, doctor?

A I certainly hope not. No, it's dye.

Q We may use this again.

Doctor, I'm going to put this up. And if you would step around and explain to the jury what that is. And if you could also explain whether or not you looked at CT scans of Mr. Allen in January of 1999, and explain what the CT scans were of, generally speaking, if you can do that.

A Sure. The first x-rays or CT scans that I saw of Mr. Allen was a CT scan of the chest. This was an idealized gender-neutral body, head all the way down to feet, which are not included, stopping at the pelvis.

And in the chest, which is this area, here's your diaphram here separating the abdominal organs from the lungs

and heart. You have your lungs, which are all involved with getting oxygen into the bloodstream. It's respiration.

You've got the pump, the heart that pumps blood into the lungs to pick up the oxygen, returns to the heart and then is pumped out the aorta, or had red artery. And that distributes the blood to all portions of the body.

You can see the aorta continuing down here feeding the kidneys, which are these kidney bean-shaped organs on both sides here. It comes down, the big aorta splits into small arteries that are called iliac arteries and then branch, branch, branch, branch into whatever organ you're getting to. So the arteries are like the trunk and branches of a tree. It's how you get blood from the oxygenated lungs to the tissues that need it. So the aorta would be the trunk of the tree, and then you get progressively smaller and smaller branches of the tree as you get out of the edge.

Q Doctor, while you're there, would you explain to the jury what -- you've explained what the difference is between a CT scan, an MRI and a sonogram. But could you tell them when it is that it would be better to take a CT, when it would be better to take an MRI, when it would be better to take -- how do doctors choose, and what are they good for? Better for? Best for?

A Right. Well, that's a tricky question, because that assumes that things don't change and that all machines are

the same.

The CT scan was invented in the early '70s, actually by the company that was the recording company for the Beatles, the musical group the Beatles. And EMI, the company that was their record label, was the builder or the inventor of the first CAT scan machine. So the CAT scan's been around a long time. And it's always used x-rays to generate the picture. And we've had x-rays since medicine

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started. That's in the late -- or since radiology started, which was the late 1800s, I believe.

So CT scans in general are more sophisticate. And when you compare it to MRI, MRI just came into being in the late '80s, maybe the mid to late '80s. So that's new technology. And so the initial MRI scans were kind of fuzzy. I mean, you knew what you were looking at because you had a CAT scan, but it just wasn't as clear.

So that's kind of an unfair question, because, in general, CT is very good for a lot of stuff, but as MRI becomes better and better, and the pictures we can get with MRI now are incredibly detailed, exquisite pictures. You don't have to sit in a tight magnet and get claustrophobic anymore. It's really come a long way. So you see more and more that MR can substitute or complement CT.

Q Doctor, I'm going to move the anatomy picture here. And if you need to refer to it at any time, please don't

hesitate.

But now what I'd like you to do is explain to the jury have you selected some of the images or slices of the CT scan of January 16th, 1999, to show to this jury to demonstrate what was depicted on that CT scan?

A Yes, I have.

Q And there are actually two CT scans taken that day, right?

A Yes.

Q And I think you explained you can take a CT of the chest and a CT of the abdomen?

A Correct.

Q Were both done that day?

A Yes, they were.

Q All right. Can we take a look at the CT slices or images that you selected from the chest CT first?

A Okay.

Q And I've got three easels up, so if you want to . . .

A So I wanted to show five slices through the upper left lung, right about at this level here, from the CAT scan on Mr. James Allen on the 16th of January 1999. And, you know, I know this is Greek, but imagine, if you will, the patient is laying on his back like the loaf of bread. You're at the feet looking up upside the patient, and his head would be over on this side. And so --

Q Hang on just a second, doctor. His feet are out here?

A Correct.

Q His head's over there?

A That's right. His nose would be pointed up like in this direction behind the board.

Q And where on his body are we?

A We're in the upper portion of the lungs, where I pointed out over there.

Q Up here?

A Yeah.

Q Okay.

A Yeah, above the collarbones.

So I'll tell you right now that the left side is the abnormal side. So most of the body is symmetrical, and it's always helpful to look at the other side to figure out what it should look like.

And so we are looking, with the way we have set the

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computer settings, at the lungs themselves. You don't see a lot of detail in the chest wall. You can't really see the ribs or the shoulder blades, but you can see what's going on in the lungs very well, the air containing lungs. And on the right side you can see that the lung in general is black, it's full of air. And then it's got these branching branches in it, which are blood vessels. That's how the blood is either -- the blood is either getting to the lungs for oxygen

or coming back to the heart to go to another part of the body.

This is the windpipe, or trachea, here full of air. And then on the right side you can see that there is an asymmetry difference. There is a mass-like finding over here that you don't see over here. There's some blood vessels next to it, but there's some abnormal density in that high left lung.

Q Doctor, let me ask you this.

A Sure.

Q Is that -- you showed us with the loaf of bread where you could start to see that black ink, got bigger, bigger, bigger. Where are we on the loaf of bread with that image?

A We're in the top. We're in the top of this mass. We're beginning to get right into it, when you just begin to see it before it gets big and you take a cut right through the big fat center of it.

And these are 7-millimeter images. And nobody knows what a millimeter is. That's 10 millimeters on me. My knuckle from here to here is 10 millimeters. Actually, that's not true. That's 25 millimeters. That's an inch. So that's 25 millimeters there. So about a fourth of that is how thick that loaf of bread is. So that's somewhere in between. That's actually a little fat for looking at lungs in this day and age.

Q Okay. So that slice of bread is seven --

A It's a 7-millimeter slice of bread.

Q Okay. And we're at the top?

A Correct.

Q And are we going to work our way down?

A Absolutely.

Q Do you need a marker?

A I have one.

So now we're getting down into the chest. And as you cut into the chest, the lungs are going to get bigger. They're pointy on top. So if you take a slice there it's a small black oval. And as you get further and further, the lung itself gets bigger and bigger.

Q Doctor, why are the lungs on these films black and everything else is white? Why is that?

A They're filled with air.

Q So on a --on an x-ray what's thick and dense is white?

A Correct.

Q And what's really vacant or airy is black?

A Right. It's all about observing x-rays. And bones are dense, and air is not very dense at all, so the x-rays pass right through it.

Q Okay.

A So you can see that the -- it looks more like a mass, where it looked like kind of a cotton ball up there, you're

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beginning to get the real sense that there is a mass in the --

Q What is a mass? You've used that word several times. What does that mean?

A It's an abnormality.

Q Something solid?

A Something solid that doesn't belong in a -- what should be a black air-filled lung. It's solid tissue of some description.

Q Thank you.

A So -- and you can see as you move down this is probably the -- I chose this one because this is right through the middle of the thing. And you can see that this white abnormal white mass or blob is -- has -- is pretty -- is easily seen. And when you measure it, you know this is the ruler over here. And we'll go over some other things, other ways you can kind of see this. But this is through the middle or the fattest part. And it's somewhere it measures a little less than two hash marks, or 2 centimeters. Remember, that's 2.5, that's 2.5 centimeters. And so this thing is less than my knuckle.

Q How would you -- is it big? Little? Medium?

A That's small. That's a small pulmonary nodule as far as preliminary nodules go.

Q Okay.

A As we cut down through we're taking more slices and we're going down. The lungs are getting bigger and bigger, so we're moving down into the heart of the lungs. And the lungs are bigger and the nodule is beginning to get smaller. You're already beginning to come out of the nodule.

As you get down to the bottom of the nodule, instead of one big blob there I'm seeing something here. I'm seeing a blob here that looks like a figure of eight, and then I see things that I'm pretty confident are blood vessels. Blood vessels are -- just match the other side. Anything that's about the same size as you see on the right side of the body, if you look on the left and it has branching structures coming out of it, that's going to be a blood vessel.

So things are getting a little uncertain at the bottom end of this, to me.

All right. Can we see the next two?

Q Sure.

A So this is what I was looking at as we were cutting out of the area of interest.

And then as you come down to this slice, which is the next slice, it went from slice 11 to 12, so it's another 7 millimeters down lower into the lung, you can see now three blobs. You see an area here, you see one here, and you see one here.

Now, both of these are bigger than the vessels on the other side, but one is pretty close. And it's my opinion that probably one of those is a blood vessel. But blood vessels should be about the same size, and yet this density or mass or blob there is bigger than that one. So I've got a density or an abnormal mass here. I've got what I believe is a second mass there. And it's my opinion that that's probably just a blood vessel that just happens to be in the

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same image.
And then finally as we come out, you can see again -- by now I hope everybody recognizes this is a blood vessel. It's got branches coming out of it. It's about the same size as that on the right, but then you've got two rounded areas that are bigger than blood vessels, and then you have some smaller areas that look very similar to the other side and are blood vessels. And so, to me, this shows two nodules that are right against each other.
So you had a bigger one, and as you came down and took more slices -- and these are thin enough slices to show that you actually saw another little mass right next to the bigger one.
Q Can you draw on that anatomy figure what you see on these five CT scans? Is that possible?
A Yeah.
Q Your interpretation of that?

A So we're up above the shoulder blade or the clavicles. And the clavicles are going to be somewhere about this level. And so up in this top part of the left upper lobe there is a small mass and what appears to me a smaller mass immediately below it. And as you cut down, you got that -- those two -- the appearance of two masses. And that was getting a bit of the big guy and then picking up the little smaller nodule right next to it.
Q Both of them small?
A Yes, they are.
Q All right. To a radiologist, what's the significance of two masses or two solid things versus just one?
A Well, it raises the possibility that this is spreading from somewhere else. When you see a single lesion and it grows over time, you're pretty comfortable that you're probably dealing with cancer because it's growing over time. But if you see two, you immediately think, well, it maybe came or started somewhere else and the lung is where it has spread to.
Q Okay. Doctor, how would you report what you see -- if you were the radiologist reviewing this CT scan, what would you say in your report?
A The --
Q So far. We were only --
A Okay. As far as this goes? An abnormal density or

opacity. We use the word "opacity" a lot these days. That's current terminology. I would say abnormal opacity in the left upper lobe appearing to represent a larger superior and smaller adjacent inferior opacity.
Configuration is complex, which means when you look at this -- and I didn't spend a lot of time with it. Some of the borders look very round and smooth on this guy here, and some of them have these kind of spiky areas that make you think of radiating rays of sun which we call spiculation.
So it's got rounded areas and spiculated portions, too. So that's -- I would determine that as a complex appearance.
Q What does roundness indicate, if anything?
A Well, actually there's no rules. But we like to think if it's round and smooth it's more likely to be benign. And if it's irregular and spiky it's more likely to be malignant.
Q All right. Does it really matter whether it's round and

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smooth or spiky in terms of whether it started in that spot or whether it came from someplace else?
A Not particularly. In fact, you can have things that are very high grade cancers that are very round and smooth. Similarly, you can have old T.B. can be spiky and aggressive looking. So in any given case the rules don't hold.
Q Doctor, you get to see both upper and lower lobes of the lung in the chest CT, don't you?

A Yes.
Q But what you've just talked about is just the upper --
A Correct, the upper left lobe, which is -- this left upper lobe is this one. This is the left lower lobe here.
Q All right. Now, did you pick out some slices of the CT scan of the chest taken on January 16th, 1999, of the left lower lobe?
A Yes, I did.
Q Can we look at those now?
A Sure. I hope everybody's becoming a weekend radiologist. Same patient, James Allen, 16 January. We can see the slice numbers are getting higher and higher. We're now to 18, 19, and 20. Then we will look at 21 down there, too.

This is down into the middle portion of the lung. We're getting into this area now. And you can see that there's beginning to become a big white blob in the middle which is going to be the heart, aorta and vena cava. That's pumps. We're getting into the level of the pump. And actually the left upper lobe sticks up to about the level of -- actually there's kind of -- here's your windpipe, or trachea here, this ringed structure here. It comes down, and then this windpipe is going to branch into a right and a left windpipe, called bronchi. And you got a right and a left main stem bronchus. So this is the level where the windpipe

is beginning to split. It's gone from a round configuration to more of a -- getting oval, splits into two and even further into two, one to the right and then one to the left.

So we're kind of at the middle of the lung, upper middle. And, again, remember, the right side is going to be our normal comparison. Patient's on his back, you're at his feet, his head is over on the other side of the poster board, and you can see branching, arteries and veins on the right side and on the left side, and then you see an abnormal density in the left lower lobe. This is the superior segment of the left lower lobe.

Again, just like we did with the upper lobe, one, you cut it through the top, then you take a slice of bread through the middle, it starts to get bigger. Then you take another slice as you move further down and it still is in the middle portion. So you can see that this -- it's too big to be a blood vessel. And again here.

And interestingly, this thing is about the same -- there's my hash marks here. That's 2 centimeters. And this thing is, in general, right around two centimeters. That same less than a knuckle breadth there.

Then as one moves further down into slice number 21 it's beginning to get smaller again, and I don't see it too well. And, in addition, there's a little sign that we radiologists see, and I -- I wouldn't expect -- called an air

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broncogram. And I don't expect this to see too well. I don't know if you can see that in addition to this white nodule there is a black area, just a little thin line, a black line in the top part of this thing. And that's what we call an air broncogram. That's a normal airway.

You know, when this -- this is a tree trunk, too. So these bronchi branch, and they get smaller, and they get smaller, and they get smaller until they're way out here and they're just human hair-sized windpipes. So this is just a small branch of the air-containing bronchus, and we call that air bronchogram. That suggests down here there may be something else going on like maybe some lung collapse or a little bit of pneumonia or something like that and not necessarily mass.

That looks mass-like. It doesn't have air bronchograms. Then as you get into the inferior part, or lower part, you wonder if there's something else right next to it.

Q All right. So what does it suggest to you in terms of whether this is a solid mass -- is this a solid mass, in your opinion?

A It looks solid to me, yes.

Q So what does that mean? Can you draw what you think you see, or what, in your opinion, you do see on the human --

A Sure. So we've moved down into the left lower lobe.

And right about the level of the middle of the lung, we call the hilum -- running out of ink here. Right about at this level there is a -- right up against the middle or central portion of the lung there's another small nodule.

Q What's the significance in terms of whether this might be an original site of cancer versus a metastasis from somewhere else where you're seeing now multiple masses or lesions or opacities or whatever you want to call them in the lung?

A Well, it's kind of common sense. I'm sure everybody knows now that this thing has spread far and wide. I mean, you've probably seen a lot of stuff, and we'll probably go through it later, that wherever this cancer arose from, wherever it started from, it spread into a lot of different portions of the body.

So common sense says if you have something that's malignant and it begins to spread, then where it spreads to you have multiple metastases, or multiple points of spread. It can only arise from one place. But when it starts to spread, it can -- it's going to be multiple because it has gained access to the bloodstream or the lymphatic system and used that to spread. So if you see multiple lesions in any organ -- and we're talking about the lungs here -- that would suggest, I mean, it came from somewhere else. That's where it spread to, but it doesn't start there. It started from

somewhere else where there should be one lesion or one mass or one cancer, and then as it spreads it spreads in multiple places.

So the fact that we see three, if not maybe perhaps even more spots or nodules in the lung, suggests that it came from somewhere else. And this is just -- we're just seeing where it has spread to.

Q Doctor, did you also look at the CT scan of the abdomen?

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A Yes, I did.
Q We talked about everything that is abnormal and remarkable that is present and that you see on the CT scan on the chest?
A Well, there is actually some disease in the lymph nodes in the chest, too, that we have not gone over yet.
Q Could you please go over that.
A Sure.
Q Do we have the right images up?
A That's what I was hoping.
(Brief Pause in Proceedings.)
THE COURT: Doctor, could we take -- I'm sorry to interrupt you. We will take a brief recess at this point. Just a short recess.
You folks step into the jury room, please.
(The jury exits the courtroom.)
THE COURT: It was requested by the jury. You

understand that the jury requested it.
(A recess was taken from 2:10 p.m. to 2:25 p.m., after which the following proceedings were had:)
THE COURT: Thank you. Bring the jury. I'm sorry about the interruption, but they handed me a note that he really needed a recess.
(The jury enters the courtroom, after which the following proceedings were had:)
THE COURT: Thank you. Be seated, please.
Mr. Reilly.
MR. REILLY: Thank you, Your Honor.
BY MR. REILLY:
Q Doctor, I think we were just about to imbark on the CT of the abdomen, or had I not gotten that far?
A No, not yet. We were going to look at one last finding in the chest.
Q I'm sorry. Now I remember.
Would you please step back down, and I think we were going to talk about the abnormalities in the hilum?
A Yes. So this is actually the same slice. If you look up in the corner where we've been looking at the IM number, that's the slicer imagine number, it's 19. And we simply told the computer to show us not the lungs, turn the lungs black, but show everything, show the soft tissues.
And suddenly you can see the shoulder blades, the

muscle of the shoulder blades. You can see the spine. That's the vertebra. Patient's on his back. You can see the pectoral muscles. This is the sternum, or breastbone. This is the aorta sliced, tube sliced in this fashion to look like a round structure.
And what I want to show you was at the same level of this left lower lobe mass there is a -- this is an abnormal mass here. This is the normal aorta, this is the aorta that goes up, it does a loop and comes down. This is what we call the ascending aorta, and this is the descending part of the aorta that goes to the rest of the body.
So at this same level there is a mass here that doesn't belong here. And actually there's probably two masses. There's a lump here and a larger lump here. And it's about the same size as the aorta. If you took in your mind and superimpose that aorta on that mass, they're about the same size. So that's abnormal lymph nodes. That's also,

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to me, indicative of cancer that has spread in this case to the lymph nodes.
Q Can you show on the figure of the anatomy where this is or have you already done that?
A Well, it's pretty much at the same level of this left lower lobe nodule. So, in fact, it's called the AP window. I don't know if we will ever talk about that, but the AP window is the little crack between this red aorta and this

blue pulmonary artery. It is right there. That's the AP window, this gap. And right in that gap between those two arteries sit a collection of lymph nodes. You have lymph nodes everywhere in your body, but that's where this particular collection is.
Q All right. Now, have we covered all the remarkable abnormalities in the CT chest film?
A Yes, sir.
Q Thank you.
Shall we move to the CT of the abdomen taken on the same day?
A This is just a single slice through the abdomen, again on the same day, 16 January, on Mr. James Allen. And this is a slice, what we call a slice through the kidneys. So it's right about this level right here. And the -- for those of you that are paying attention to some of those numbers, now you can see that the slice of bread is actually a little thicker on this one. It's now saying 10 millimeters instead of seven millimeters. So that's just a practical consideration as much as -- as much as anything. There's a lot of slices. It takes time, it takes radiation to take slices. So 10 is a more common slice thickness when you get into the abdomen to get from top to bottom in a timely fashion.
Q On the chest they were at seven?

A They were at seven. They were thinner slices of bread, and these are thicker slices.
Q Does that make things on the CT scan seem a little smaller?
A It can. It's the analogy we were using with the food dye in the loaf of bread. And the general principle is you can -- remember when I took the bunch of slices together and you wouldn't see the nodule at all? The general principle is you can make something smaller but you really can't make it bigger. All right? So in general, things we do in radiology by choosing different techniques it's -- it could be smaller, but it would be hard to make something bigger than it is. But there are reasons why it could be smaller. So in general, that could -- anything you see on a CAT scan could be smaller, but it's not going to be bigger, in general.
Q So what do you see of significance, if anything, on this CT film of the abdomen?
A Well, if you took these kidneys -- and these kidneys look kidney bean-shape, and you slice the patient like that, then they're going to look like circles. So these two big circles here are the kidneys. And they've used dye or contrast.
So the kidneys have a lot of blood vessels in them. They're the blood filter for the body. I mean, they're the oil filter for the body. I mean, the blood goes to the

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kidneys, it flushes or filters the blood and it makes urine, which is waste, and you pee it out.

So they have a lot of blood vessels. So things that have a lot of blood vessels are going to turn very white bright when you give contrast.

So this vessel here, this is the spine. I'm going to get in front of this. This blood vessel here is the aorta. This is the inferior vena cava. We've got the kidneys on both sides. This structure here is the liver. There's the gallbladder, this little gray guy here is the gallbladder. This turns out to be the head of the pancreas here.

And, you know, we look at these all the time. This is all -- I could point to everything on here and tell you what it is because it's a normal or abnormal structure, but they're all in the same place. I mean, that's how the body's put together.

So this thing here is the pancreas. You've got the kidneys. Actually, the liver is removed from this picture, but the liver would be right here, and the gallbladder would hang out just below the liver. And then the stomach has been removed, but the stomach would sit in here. And then it goes into the small intestines in that direction.

Q I'm sorry to make you kneel down like that, doctor, but . . .

A That's okay.

So what I wanted to show on this picture is the kidneys are usually smooth circles. And that's really, once again, we've got a right and a left kidney for comparison. And this kidney is not quite -- the left kidney is not quite smooth and circular. There is a wedge-shaped area here that's not as bright, and then there's a bump or mass up here.

So this is -- this wedge-shaped defect is very characteristic for a -- what's called an infarct. It's a stroke of the kidney. You blocked the blood supply. You lopped off one of the branches. Remember the branches of the tree go and they branch, and they branch, and they branch as you get -- so the blood supply does that same thing. If you take out this branch, all the little vessels that branched off it are now plugged up and that part dies. So that's called an infarct, a renal infarct. And that's a fairly characteristic picture.

And they're common. People get little bits of tissue that die, particularly as they get older. And so at this level of this infarct we see this rounded area that's not normal. That's not a normal finding.

Q Can you tell what that is just looking at it right there?

A Not particularly. I mean, you can give a difference of

diagnosis, your top three or four possibilities, but you probably need to do other studies to work that out.

Q As it looks right there, what are the top one, two, three or four possibilities.

A Well, I think the thing we always worry about the most is cysts, kidney cyst versus solid mass. Cysts turn out to be pretty common in the kidneys. And the older you get the more cysts you can see. So that's probably the big two is is

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it a solid mass or is it a kidney or renal cyst?
Q Solid mass means cancer?
A It could very well mean cancer.
Q Cyst means probably not?
A That's right. Overwhelmingly, if you have a cyst, that's no big deal.
Q Looking at the right kidney, do you see any similar abnormal bumps or things of note?
A Well, I think most of the people that are looking at this would wonder if -- there's nothing as big or as noticeable as you see on the left side. But you would wonder if there's some little spotty areas on that right kidney, as well. Not as worrisome -- to me, not as worrisome on this left kidney.
Q What's the size of that structure on the left kidney?
A Well, using the hash marks here, my index fingerer is going to be about a centimeter. And this thing is a little

more. It's a finger and change. So it's going to be a little bigger than a centimeter. That's 2.5 centimeters. So it's going to be on the order of half of it, or a little less than half of my knuckle.
Q How does that compare with the mass you found in the left upper lobe of the lung?
A Well, nothing we've seen is bigger than my knuckle. They're all sub-knuckle sizes. So they're all about the same ballpark. I mean, there's nothing that's been bigger than that that we've seen. It's always a fraction of that.
Q Okay. When you see a structure like that, what do you, as the radiologist, report? What do you do?
A Well, you would identify it. You would mention a wedge-shaped defect in the posterior left kidney, appearance typical for infarct, renal infarct. In addition, a mass, or mass-like lesion, projecting off the lateral -- the side, the lateral aspect of the left kidney. And then you'd need to do some more studies to try to define better what it is.
Q Can you just order that yourself?
A No. Typically, we have the doctors -- we would put it in our impression, you know, recommend further evaluation with ultrasound or fine section CT, and usually it's the ordering doctor that orders that.
Q So what would you -- if you had been the radiologist interpreting this CT of the abdomen, what would you have

recommended?
A I think probably the most efficient way to look at it further is to get an ultrasound. I mean, it's cheap, there's no radiation, it's quick. You don't have to prep for it, you don't have to get an injection of iodine or oral contrast. It's very quick.
Q Would you have waited six months to see what happened with that thing?
A Personally, I would not have. I mean, you have a chest that we just looked at that's got nodules and enlarged lymph nodes, abnormality, and now you've got this. I think that this is the time to work these things out.
Q All right. Doctor, let's -- I'd like you to take your seat, and I'll have you back here in just a little bit.
But if we could look through the actual interpretation performed by the treating radiologist. At this point I'd just like to make a quick comparison of your

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interpretations versus those that were reported by the treating radiologist. Okay?

This is the CT of the chest, correct?

A Correct. It says CT chest, with contrast. There's a 1.6 by 1.8 centimeter spiculated mass lesion in the upper lobe of the left lung, which we saw. There is metastatic disease to the left hilum and left side of the mediastinum, which we saw. That was that AP window slide that we looked

at.

No other pulmonary nodules are identified. Well, we talked about that left lower lobe, left lower nodule, and we actually questioned if there was actually two nodules in the left hole. There was no plural effusion. That's fluid on the lung. Just like you can get fluid on the knee, you can get fluid on your lung. There are no obvious metastatic lesions to the bony structures of the thorax. I looked at these films. We didn't put every picture up. It's like 50 slices of the CT scan. But I didn't see any metastatic lesions either.

Q Are there things that are left out of here?

A Yes.

Q What things are left out?

A The multiple pulmonary nodules are the ones that I would think is most important.

Q All right. Doctor, this is the interpretation of the CT of the abdomen, correct?

A Yes, it is. And it says: This study is done with oral and intervenous contrast, which is true. That's IV and the drinking. There's no evidence of metastases to the liver or spleen. We didn't look at every picture, again. Abdomens are about 60 pictures. But I agree with that.

The pancreas and adrenal glands are normal. That's true. And there are no an maladies seen in the kidneys.

Well, we just spent some time with that. I think that there was -- I would perhaps mention those things, to be honest with you.

The intestine loops are normal, Yes. No obvious soft tissue masses. We didn't show all the pictures, but actually, there is a soft tissue mass in the muscles of his lower right back. You have muscles on both sides of your spine you can feel in your back. And there is -- on the right side there was an area that enhanced or took up dye, and it was asymmetrical. When you looked at the other side, when you compare side to side, and it was very suspicious for a soft tissue metastasis.

Bone windows show a lytic lesion in the lumbar spine. I did look at that, and it was there for sure. He said lytic lesion in the anterior aspect of the spine, and does not appear to involve posterior structures of the spinal canal. I agree with that. What he's trying to tell the doctor is it's not going to paralyze the patient, you know. If it -- if things involved the front and back of the spine it can squeeze the nerves and cause paralysis. That's a very big deal, and so you have to communicate that.

Q This doesn't -- obviously since there's no mention of an abnormality in the kidneys there's no recommendation for further studies of the kidneys, right?

A Right.

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Q Your report would say . . .
A I would say abnormal kidneys with suspicious mass lesion of the left kidney of uncertain etiology. Further work-up recommended, and could include ultrasound.
Q All right. Doctor, I'm going to take you directly to the next radiographic procedure that was done. That's an MRI, correct?
A Yes.
Q And can you step down again and put the MRI up? And that MRI was done on January 26th; is that right?
A That's correct.
Q Does that MRI tell you -- does it tell you the answer to the question of whether or not that's a solid mass in the left kidney?
A Yes, it does.
Q Does it also tell you whether or not any of those bumps on the right kidney are of any significance?
A Yes, it does.
Q Would you please explain that to the jury.
A Yes. First of all, this is a great example of I told you MR was fuzzy. And, you know, this is -- at that time this is about as good as it gets. They've gotten a lot better. But it depends on what kind of machine you get in whether it's a clear picture or not.
But it is -- I'm sure you recognize the same

anatomy. Here's the liver, there's the gallbladder, here's the right kidney, there's the spine. It doesn't seem bright white. Aorta, inferior vena cava, these are the muscles of the back. In fact, it was this muscle that had the abnormality I thought by CT that I thought was a spread of cancer.
And you can see that somebody's already circled this, but the right kidney, to start with, looks pretty clear, looks like somebody took a black pencil and drew a black line all the way around the kidney. I don't see any bumps or masses that would concern me.
On the other hand, on the left kidney -- the left kidney there is a bump here. And this is not a good picture of it. I showed this because this is without contrast, and this one is following contrast.
So it's the same principle. The kidneys have a lot of blood supply, so they're going to light up. They go from gray to bright when you give MR contrast.
And you can see that there's contrast in the aorta and the inferior vena cava. Everything is lighting up nicely. And you can see that here's our familiar renal infarct, the stroke or the blocked artery in the kidney that's left the scar. So we know that's the right level to be looking at.
And there's the mass right here. And it lights up.

It looks the same. Cysts won't do this, but that bump looks the same as the kidney tissue, the renal cortex without and with contrast. So whatever this is, it's got blood vessels. It's got vascularity. It's not a fluid-filled bag, a cyst.
Q Doctor, let's take a quick look at the order from Dr. Sue tar that caused this MRI to be taken. Actually, what I'm going to put up first is the decision tree of Dr. Sridhar. Doctor, this exhibit is already in evidence.

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Your interpretation of this decision tree by Dr. Sridhar indicates what?
A First of all, he's to be commended. I can actually read his writing. That's not common with doctors.
But on the first line it says: MRI kidney. Then it says: If negative, favor left lung clear cell. C.A. is for cancer, it's an abbreviation for cancer.
Then on the next line it says: Chemo. So I guess what he's saying that if the MRI of the kidney is negative, he's going to assume that it's a lung cancer because the kidneys are negative, and treat with chemo.
Then it says: RT, to right foot. So they're going to radiate the right foot I would imagine is what he's saying there to stop that disease. I mean, you have to walk, so you got to treat that.
Then the arrow goes down. Then it says: If positive for renal primary, I believe, transfer to . . .

Q Dr. B?
A Yeah, Dr. B.
Q All right. Doctor, at this point this document is dated January 25th, the CT scan results from the abdomen of January 16th are already in, aren't they?
A Yes, they are.
Q And here's Dr. Sridhar still thinking that this may be a kidney lesion, kidney primary, and we need to do an MRI?
A Right.
Q At this point he's been advised through the report of Dr. Messenger that there's nothing on the kidney, right?
A Correct, if he's read that report.
Q Now, based on your review of the MRI of the kidney, what information should Dr. Sridhar have received?
A Well, that there was a mass on the -- a small mass on the left kidney.
Q Did he get that information?
A I've had the opportunity to look at the report. No, he didn't, unless he looked at the films.
Q Well, let's take a look at the order that he entered. What is -- this document's also in evidence, the MRI Center. Is this the order that Dr. Sridhar made?
A I don't know. I would assume --
Q You haven't seen it?
A Right.

Q I will inform you that this is the order that he made. What's he asking for?
A Well, it gives the appointment time and the date, and then it says: MRI scan of, and he's written in -- or somebody's written in both kidneys with Gad, which is the contrast, and without Gad. So he wants it with and without contrast, which is how we look for tumors. And special attention to, he didn't put anything. And then he says: Diagnosis, rule out -- R.O. is rule out -- primary lesion in kidney, clear cell C.A. Again, abbreviation for cancer. And then his name, Sridhar.
Q So what is Dr. Sridhar asking the radiologist at the MRI Center to look for?
MR. COHEN: Objection, Your Honor.
THE COURT: I think you're asking him to interpret Dr. Sridhar's mental processes now. I mean, he can -- I think perhaps he could answer a question like: Reading that,

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what should Dr. Sridhar have done, or something of that sort, what instructions was he getting.

MR. REILLY: Your Honor, I can reform the question.

THE COURT: All right.

BY MR. REILLY:

Q As a result of that order, should Dr. Sridhar have received back information regarding the tumor on the kidney?

A I believe so.

Q Let me show you the report of Dr. Morillo dated January 25th. Okay? You've seen this before?

A Yes, I have.

Q First of all, under the MR exam requested, what is being requested according to this form?

A It says: MRI of the abdomen and retroperitoneum, with MR angiography with Gadolinium. So they want an MRI of the abdomen. The retroperitoneum is simply the area that the kidneys live in. That's their position or location within the abdomen. And then MR angiography is a technique where you can look at blood vessels. You can look at the aorta or the -- you actually can look at the inferior vena cava if you do some tricks.

Q Under history, what is the information that's reported there that Dr. Morillo had regarding what's going on with the patient?

A He's been given the completely incorrect history. They're looking -- it says that he's got severe -- patient with severe high blood pressure or hypertension, and they're looking for a cause of that, which is called renal artery stenosis. So they're looking more at the arteries that feed the kidney to try to decide why he's got high blood pressure.

Q The order we showed you in the decision tree you just saw from Dr. Sridhar, is there any indication of a suspected renal artery stenosis for this patient?

A Not in anything I've seen.

Q Any reason for the history to indicate that the evaluation is for a suspected renal artery stenosis?

A It doesn't get to what we've been talking about. We've been talking about cancer and masses and spread.

Q When Dr. Morillo got that history, is it any wonder that he didn't focus on the mass on the left kidney?

MR. COHEN: Objection, Your Honor.

THE COURT: Sustained as to the phraseology of the question.

MR. REILLY: I'll rephrase it, Your Honor.

BY MR. REILLY:

Q If you, as a radiologist, were being asked to evaluate for a suspected renal artery stenosis, where would your attention be focused?

A Right on the renal arteries.

Q Is that the same thing as looking for a mass on the left kidney as you've identified?

A No. And, you know, you like to say that you'd make every observation on every patient all the time. But there are good days and bad days. And some days you're on, and some days you're not. To me, in my opinion this is misleading. You're going to spend your time really looking at an entirely different part of the kidney than what I think we've been talking about so far.

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Q Does Dr. Morillo make any mention of the tumor on the left kidney?
A No, he doesn't.
Q Doctor, I'd like you to take us directly to August 22nd, 1999. And if you wouldn't mind stepping down. Another CT scan was taken on that day?
A Right.
Q All right. Is that the next time that -- of all the films you've looked at, is that the next time that there was any CT or other radiographic procedure that displayed the kidneys of Mr. Allen?
A No, this was the first one. The patient had had multiple CAT scans of the chest. And when you do a CAT scan of the chest, I mean, you have to have a start and a stop point. And the accepted standard of care, what everybody does is they start above -- this is your shoulder. This is your shoulder. So you've got a clavicle that comes in like this. You start above the clavicles to include the upper portion of the lung, and you go through the upper abdomen to the level just at the top of the kidneys called the adrenal glands.

There's these little triangle organs that sit right on top of the kidney called the adrenal gland. So you go through the adrenals. So that's -- no matter where you go in America, if somebody gets a CT chest it's going to include

from the lung apexes through the upper abdomen to include the adrenals.

So everything in this mass we saw, this line is where that cut was, this mass is sitting here. So nobody was scanning the abdomen. So that area was never included on any scan up until the one you just mentioned. That was the first time that the CAT scan had gone down far enough to include the lower kidney. So that was the next time.
Q All right. Would you put up whatever parts of the CT scan of August 22nd of -- this is a -- this is a scan that went down far enough to actually see the kidney, right?
A Correct.
Q And can you show the jury what is of significance on that CT scan?
A So I put up the one from 16 January just to compare. And it's about the same slice. I mean, you can't duplicate things precisely, but it's pretty close.

This is a more modern machine. This is the new spiral scan. That's what this little squiggly thing is there. It's called helical scanning. And that's a new technology leap in CAT scans.

But you've got the kidney again. You've got the liver. You've got the gallbladder.

Now you see this thing in the liver which represents further spread of cancer. But what I wanted to

draw your attention to is here's the renal infarct. We know we're at the same level. And that little mass on 16 January is now right here. So we can see that it's a mass that arises in the renal cortex, the filtering part of the kidney, the filter part of the kidney, the outside cortex of the kidney. And when I measured I thought this thing had probably quadrupled in size. I mean, you can kind of do in your mind's eye the math between the hash marks in comparing

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it to that mass on 16 January versus what the mass looks like. And the hash marks are over here. Now I know that compared to -- now it's sticking out substantially further, and it's also beginning to extend into the cortex a little bit.

So this is -- that little thing has grown to this. We know we're at the same level, because this is our marker that it's the same slice or bread slice in the kidney. And then we've got that liver finding.

Q What's the size of that tumor now?

A Well, I'll give it four fingers, four fingers there. So, you know, actually this is how we measure things a lot. It looks like it's on the order of four centimeters in greatest dimension.

Q So it's four times larger than it was?

A About, yes.

Q Lot of growth?

A Lot of growth.

Q Single or solitary lesion?

A Well, that's a good point. We're only looking at one picture here. But remember, we slice the bread and we looked at all -- I looked at all the slices of the kidneys, and there was nothing in the right kidney at all, and there was only this mass in the left kidney.

Q As a result of this radiograph and this CT scan and its interpretation, was a sonogram ordered?

A Yes. As I recollect, this was the interpretation that made the observation and recommended the ultrasound.

Q Okay. And was that done?

A Yes, it was.

Q Can we show that to the jury?

A Sure. Ultrasounds are really hard to understand. They're very difficult to see. But imagine that there is a kidney bean-shaped structure. And you don't see it here because the -- it's not included. But I can see -- sorry. Right to here. But there is a kidney bean-shaped mass. It looks very much like the kidneys. We're looking over there. And it's not cut like the slices of bread, it's showing the whole kidney, very much like that picture does, it sits on its side.

So, you know, it is that structure just magnified, this -- that kidney thing -- kidney bean-shaped organ is this

organ right there. It's just looked at with sound waves so it's kind of a fuzzy image. But the inside of the kidney called the sinus has fat in it. So it's got the bright speckles, and the cortex is darker. And that's the way a cortex looks.

And, remember, the bump was on the bottom outside of the kidney. And if you follow this border here, suddenly there's a bump on the outside kidney, and then -- you're not going to see it there.

But that is the mass that you were seeing on the CAT scan. And it is -- it looks every bit the same to me as the cortex. The amount of gray as this thing here looks the same as the gray here, looks the same as the gray here. So that tells me that it's solid. It's not a cyst, but it's indistinguishable from solid renal cortex on that sonogram.

Q What's the significance from the time or arising from the renal cortex as opposed to the renal pelvis?

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A Well, there are different structures in the kidney. And cancer is going to rise from different parts of the kidney. So this suggested this cancer arose from the cortex. It's not sitting in the middle to make you think of tumors that arise from the middle of the kidney. There's things called transitional cell cancer and so forth that live in the -- start in the middle of the kidney. But it tells me that this mass started in the cortex, so it arose from the cortex.

Q So this is a renal cell carcinoma?
A Yeah, that's the technical term.
Q All right. Doctor, any doubt in your mind now that this is a cancer on the kidney?
A No, sir.
Q Any doubt in your mind that this is a single mass?
A No.
Q What's that suggestive of, compared to the multiple lesions in the lung?
A Again, it's detective work. It has to start somewhere and spread somewhere else. So we found a single mass in the kidney, and we have multiple masses in other parts of the body. We've got things going on in the liver, we have got things going on in the lungs, things going on in the bone, in the foot of the bone -- bone of the foot, I'm sorry. And you have one single kidney mass. So I would think, more likely than not, it started in the kidney and spread to other parts of the body. I don't have multiple kidney masses, I have one kidney mass.
Q Is that opinion based upon a reasonable degree of medical probability?
A Yes, it is.
Q Doctor, I'd like to cover one more topic with you. And that is the response to treatment that Mr. Allen had between August and September of 1999. We have some films that

reflect that.
A So these are pictures of that AP window area that we're talking about earlier hat nest of lymph nodes that lives between the aorta and the pulmonary artery. And this is the picture we looked at first, the image we looked at first showing -- and there's -- I apologize, but these are not all the same technique. I mean, this one is without contrast, the aorta is very dark. And then the other two that we're going to compare to is with dye, or contrast, and suddenly everything that has blood supply to it turns very bright.

But this was the mass we talked about that we said, gee, you can fit about, in your mind's eye, an ascending aorta would probably swallow that mass or is about the same size when you compare it. And the aorta is not going to change in size in an adult person. He's not growing anymore. So that's going to be kind of our internal ruler.

Then you can see from 16 January to 12 July that the mass is beginning to get bigger. Suddenly this aorta -- I think if I put it in there I've got stuff left over on the side. So it's now exceeding the diameter of the aorta. So it's beginning to grow.

And then you can see on 22 August, '99, that this thing has -- this thing has really grown. And not only that, there's some things that radiologists look at. This area here looks a little darker than this rim around it,

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suggesting that it may be beginning to outstrip his blood supply and the internal portion could be beginning to die or necrose.

But use your internal ruler, the ascending aorta, and you can perhaps fit two -- I might get two and change, or maybe almost three aorta diameters in that mass by the examination 22 August, '99.

Q Doctor, are you familiar with the treatment Interleukin 2, IL2?

A In general. I'm not an oncologist, but . . .

Q I understand that. But you understand that's administered to patients for the purpose of treating renal cell carcinoma?

A Yes, I am.

MR. COHEN: Objection, Your Honor. He said he's not familiar with it. In addition to that, he was not going to be rendered or offered as an oncologist on oncology treatment.

THE COURT: What was your question, please? Or can you rephrase it?

MR. REILLY: Sure.

BY MR. REILLY:

Q Doctor, are you familiar with IL2, Interleukin 2, as a treatment for cancer?

A In general terms.

Q All right. Do you know what kind of cancer it is administered for?

MR. COHEN: Again, Your Honor, my only objection is that Dr. Deprima has been qualified as a radiologist, and he even stated in his deposition he's not going to offer opinions on oncology, treatment . . .

THE COURT: Overruled.

You may answer the question.

THE WITNESS: Can you repeat the question?

BY MR. REILLY:

Q Sure. Do you know what kind of cancer IL2 is administered for?

A It can be used in renal cell cancer.

Q All right. I'd like you to assume that on August 27th, 1999, after the August 22nd CT scan, just three days after the sonogram that was -- that we've been talking about came back confirming that there was a kidney lesion which was solid, Dr. Sridhar ordered IL2 for Mr. Allen.

Would you further assume that on August 28th Mr. Allen started receiving a one-week course of Interleukin 2.

Assuming those facts, do you have an opinion as to whether the change in treatment most probably explains the shrinkage of the tumor in the mediastinum that you've just been telling the jury about?

MR. COHEN: Same objection, Your Honor.

THE COURT: Well, I'll permit him to answer if he feels he is qualified to answer that.

THE WITNESS: So you're asking me to assume that the patient was treated for renal cell cancer between the 22 August study and the 10 September study?

BY MR. REILLY:

Q Yes, doctor.

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A Well, this thing is smaller. I mean, do the math. You look at that one and look at this one. Here's your aorta for your internal mind's eye ruler, and look at the size of the mass there and look at the size of the mass there. It's clearly smaller. And what happened in between was he was treated for -- with Interleukin 2.

As radiologists, we do follow-up studies in patients that are being treated to assess interval change. This is interval change. And it's changed from there to there. And that's what you report back to the doctor. It has shrunk by about 50 percent at least from there to there. And if he's been treated with something and it shrunk at the same time . . .

Q Doctor, let me ask you a couple of other questions, and then I'm done.

Can kidney cancer metastasize to the feet?

A Yes, it can.

Q Can kidneys -- can kidney tumors the size of the one that you identified on the CT scan of the abdomen of January of 1999, can they metastasize?

A Yes, even small ones can metastasize.

Q Do they oftentimes metastasize to the lung?

A Yes, they can. That's one of the common places.

Q In your opinion, doctor, where did this cancer start?

A I think this was a small renal cell cancer that spread to other parts of the body. That is the easiest way to fit all these pictures together and explain it from a radiologic perspective.

MR. REILLY: Thank you, doctor. No other questions.

THE COURT: All right. Would you resume the stand, doctor.

Dr. Deprima was on direct examination at this point; is that correct?

MR. REILLY: Yes, Your Honor.

THE COURT: All right. If -- is it convenient for you to proceed at this time?

MR. REILLY: Judge, considering I have to start at about 3:15 on a Friday afternoon, I think I would opt to go ahead and let's get going, as long as it's the pleasure of everybody else.

THE COURT: Go right ahead. Cross-examination.

Cross-examination

BY MR. COHEN:

Q Dr. Deprima, my luck I got to talk to you on a Friday afternoon at 3:15.

THE COURT: It's a lot better than Saturday, which it might be if we don't start, you know, moving this thing along.

BY MR. COHEN:

Q Doctor, we know each other, don't we?

A Yes, we do.

Q We know each other outside the context of this case, don't we?

A Yes, we do.

Q We like each other and respect each other's opinions, don't we?

A Yes, we do.

Q But in this case we disagree?

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A I don't know what --
THE COURT: Ask him a question, please.
MR. COHEN: I am, Judge.
BY MR. COHEN:
Q We disagree at least with respect to some of the positions you're taking on behalf of the Defendants in this case, and certainly the position of the Plaintiff with respect to what is seen radiographically?

MR. REILLY: Objection.
THE COURT: The objection is sustained. Please, whether or not you and the witness agree or disagree is totally immaterial, ladies and gentlemen. That -- what now he's getting into comes in argument. In argument he can tell you whether he agrees with anybody or not. But asking witnesses whether they agree with him or disagree with him is totally improper.
Now, let's ask him some questions about his direct examination. Sorry to interrupt you, but let's move on.
MR. COHEN: That's fine, Judge. I'll rephrase the question.
THE COURT: All right.
BY MR. COHEN:
Q It's not uncommon for you as a physician to disagree with other physicians concerning what you see in the field of radiology?
A So you're asking me if reasonable radiologists disagree?
THE COURT: Let me rephrase it, doctor. What he's asking you is how common is it that you disagree with other radiologists looking at the same documents, but do you have disagreements? And if so, is it a common thing or an uncommon thing?
THE WITNESS: I understand.
THE COURT: I think that's what he's getting at.

THE WITNESS: You can occasionally disagree. Yes, you can.
BY MR. COHEN:
Q In fact, in the field of medicine, you certainly know about the fact doctors ask for second opinions?
A Yes, I do.
Q And second opinions are a way that a doctor might ask for someone to either agree or come up with some other diagnosis or impression?
A That's correct.
Q In fact, even in the field of radiology, you have something in your particular practice called rereads, overreads or second-reads, correct?
A In mammography?
Q In mammography, in films that are taken in an emergency room that may have to be reread over overread by some other physician, some other radiologist?
A I don't entirely agree with that. There are certain areas that we do rereads in, and mammography would be a good example.
Q All right.
A But as a matter of practice, I mean, I don't think CTs are reread very much at all. That's not standard of care.
Q In your practice, do you practice with a group?
A Yes.

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Q In your group, do you sometimes share films to look at for another opinion?
A Yes, you can share a case for another opinion.
Q You told the jury a little bit about your education and your background, your training, and you told them that you're a neuroradiologist, correct?
A (Nods head.)
Q That means you specialize in the brain and the spine?
A That's correct.
Q Now, in this case you know that you've been looking at and you've been sharing with the jury your impressions concerning the films of January 16th and some additional films throughout Bob Allen's last eight months, correct?
A Yes.
Q In that respect, you have commented about your findings and your opinions about what you saw?
A That's correct.
Q Now, are you telling this jury in any way, shape or form that you think that Dr. Messenger, for example, who interpreted the January 16th scans, that he deviated from the acceptable standard of practice in any way when he interpreted those films?
MR. REILLY: Objection, Your Honor. Irrelevant.
THE COURT: Let me go over this with Counsel. If you all will step in the jury room, please, just for a

moment.
(The jury exits the courtroom.)
THE COURT: Doctor, if you would be so kind just to wait outside just for a minute in the lobby just for a moment. Thank you. Just out there in the lobby just for a moment, thank you.
All right. Now, if this were a medical malpractice case, of course, this would be a perfectly proper comment. But what I'm concerned about here is one witness commenting on another, then we bring that witness back to comment on this witness, and next Thanksgiving we're still here talking about what doctors think about each other.
This last question seems to go to whether or not Dr.-- whatever the gentleman -- the doctor's name was, committed malpractice, as I understand the question. Was that the thrust of it, or what . . .
MR. COHEN: The thrust of it, Your Honor, is whether or not the other radiologists in this case, who have read these films and have interpreted them, and Mr. Reilly specifically asked if things were left out.
I am asking whether or not the things that were left out by these other radiologists constituted deviations from that practice of radiology. Because the impression left with this jury, unless I have a fair cross-examination on this issue, is that all these other doctors were wrong in

their medical diagnosis.
THE COURT: Whether you have a fair cross-examination or not, the impression is here now. Let's talk about what impression has been left and deal with that. Don't get into -- you'll get a fair cross-examination if you give the Court half a chance here.
What is this -- he says right now the impression is left with the jury that -- and I don't know the other

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doctor's name. Somebody -- Sridhar?
MR. REILLY: Sridhar.
THE COURT: All right. Dr. Sridhar's examination was so faulty as to be --
MR. REILLY: I'm sorry. I misstated the name you were thinking of. It's Dr. Messenger.
And, Your Honor, I haven't indicated at all that Dr. Messenger deviated from appropriate care.
THE COURT: Well, what have you left with the jury? What -- how would you be arguing that if you were arguing it to the jury?
MR. REILLY: What I would be saying is the reason why Dr. Sridhar treated the patient as he did for cancer of the lung was because he wasn't informed that the radiologist had -- should have or did see or would have seen, if he had really looked for it, this tumor on the kidney. Not as a deviation from care, but only because this explains why

Dr. Sridhar went ahead and treated the patient for lung cancer.
What I've shown is -- I don't know whose is on. What I've shown is with this exhibit that Dr. Sridhar had a decision tree. And on his decision tree he says, I'm going to wait and see what the radiologists tell me. If they tell me there's a kidney tumor, I'm going to treat him for kidney cancer. If he tells me that there's a tumor -- if he tells me there's no tumor on the kidney, I'm going to treat him for lung cancer. That's the only reason I am showing this -- of course, I also have to show the jury that there really is a tumor on the kidney, which Dr. Messenger has now admitted there is.
Now, I have to do this for two reasons: I have to show there truly is a tumor on the kidney, which I did --
THE COURT: All right. The question is having demonstrated that to the jury through this witness, we've got to talk about the range of cross-examination.
MR. REILLY: Right.
THE COURT: My concern is getting doctors pointing the finger at each other and -- in this case, because I don't want to be trying a medical malpractice case if I can avoid it.
So therefore what I'm concerned and -- about and dealing with is an evidentiary problem, and respecting the

fact that on cross-examination there is a wide or broad latitude in developing the matters that have been brought out on direct. Here, the purpose of this testimony and the thrust of it was that Dr. Messenger did not report to the treating doctor the tumor on Mr. Allen's kidney.
The thrust of this last question is whether or not, by not reporting that, this doctor that's now on the stand, Deprima, Dr. Deprima, P-R-I-M-A, has an opinion as to whether or not Dr. Sridhar --
MR. REILLY: Messenger.
THE COURT: Messenger is the radiologist? Whether he has an opinion that Dr. Messenger departed from the standard of care in the community governing radiologists in not reporting the cancer on the kidney.
All right. Cross-examination is broad, and I'm going to let him ask that question. I am concerned it's simply going to open it up to another -- another tangential

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issue that everybody's going to want to address over and over, but the objection is overruled.

Bring the jury.

(The jury enters the courtroom, after which the following proceedings were had:)

THE COURT: All right. Mr. Cohen.

MR. COHEN: Thank you, Judge. With the Court's permission, I'll continue.

BY MR. COHEN:

Q Dr. Deprima, my question to you, sir, is: In your analysis to the jury, comparing your findings with that of Dr. Messenger, are you telling this jury that Dr. Messenger was negligent as a physician based on his interpretation?

A No, I was simply pointing out findings that were on the films. That's not my perspective at all.

Q Okay. That goes with the two radiologists can disagree?

A Well, the pictures don't lie. I mean, we've pointed out on the picture -- we're talking about findings, in part. And we're talking the findings are the findings.

Q Wouldn't you agree the findings on the films, as you know as a radiologist, are subject to your interpretation, ultimately your impression?

MR. REILLY: Well, I would object, Your Honor. Dr. Messenger has already admitted --

MR. COHEN: Judge, that's improper --

THE COURT: Just a moment. The objection is overruled. The jury will disregard that. At some point you will get to listen to very brief closing argument in this case.

Go ahead.

BY MR. COHEN:

Q Wouldn't you agree that it comes down to ultimately your impression, your reading of a film?

A Yeah, things do come down to an impression.

Q Okay. You also discussed with the jury a little bit about Dr. Morillo's MR of the abdomen and the peritoneum, correct?

A Yes.

Q And you remember that report was put up, and you came down and you showed them a little bit about the study?

A Yes.

Q All right. Now, you looked at that study, and you were able to tell the jury that you easily and readily saw a focal mass on the kidney, correct?

A Yes.

Q Are you telling the jury that with respect to Dr. Morillo, that Dr. Morillo was negligent in not seeing that focal mass when he looked at this study?

A No.

Q Okay. Do you think that a -- assuming a well-trained radiologist like yourself would miss that focal mass when looking at that study?

A Well, we need to go over the fact that I had the luxury of seeing the entire series of x-rays. And that's something that no radiologist had. I mean, these guys were at different facilities, they didn't have comparison films. I got to see a complete radiographic story. Nobody else had that advantage.

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Q That was an advantage you had?
A Yes, it was.
Q When you talk about that, is it important for even a radiologist to have a little bit of clinical information?
A Every little bit helps.
Q Okay. But yet when you were hired to blindly review this case, you didn't even know that you were being hired by tobacco companies, did you?
A Initially, that's correct.
Q When you were hired to review this case blindly, you didn't even know that Bob Allen died from lung cancer?
MR. REILLY: Objection, Your Honor.
THE COURT: Well, I'm not sure when he was hired what he knew is that relevant. I just don't know.
Would it have made any difference to you if you'd known who it was that called you and asked you to review these films as far as your opinion of what you saw on these films? Would that have made any difference to you?
THE WITNESS: No, sir. I rendered my opinion, and we went from there.
THE COURT: All right.
BY MR. COHEN:
Q Doctor, what I'm talking about, though, is just a little bit of clinical information. Did you know that Bob Allen was a 50-year smoker at the time that you reviewed the films

blindly?
A No, I did not.
Q Now, you -- you stepped down, and we talked a lot with the jury about the January 16th CT scans of the film of the chest, right?
A Yes.
Q You talked a little bit in that regard, and you told them about your findings concerning I think as you put it that lesion, which, at the very least, had some spiculated appearance and some rounded appearance, correct?
A Yes, sir.
Q But whether it was spiculated or rounded does not take away from the fact that it still looked like, to you, radiographically, cancer?
A I think what made it look like cancer was the whole series of x-rays and the fact that things grew over time. Any one snapshot or a single study you don't know what it's doing. Whether if it gets smaller, goes away in a month from now, I think the way this kept on going was what told me it was cancer.
Q In fact, what kept on going was the spread of this cancer and the growth of this cancer in the lung and to the adjacent structures of the lung?
A Well, when you looked at all the films, the lesions or the masses that were originally there, got bigger, and then

there were more numerous ones, too, new ones that popped up.
Q And that included a spread from the -- from the lung to the mediastinum, correct?
A I'm not sure you can necessarily say that. I mean, they were in both places. I don't think -- I'm not sure that it went from the lung to the mediastinum or the renal stinum to the lung. Renal cell, for instance, gets in the bloodstream and it spreads. Cancer is spread in different ways.

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Q What you saw, though, when you looked at the films, at least those initial set of films, was that you noted that there was a lesion that at least was suspicious for a cancerous tumor in the lung?
A That's fair, yes.
Q All right. And at least you would agree that what looked suspicious was additional cancer growth in the hilum and in the mediastinum?
A Yes.
Q There was this additional findings of adenopathy?
A Yes.
Q And that's the nodes that you were talking about adjacent to the structure of the lung?
A Yes.
Q Now, at the very least, as a radiologist who looks at those kind of films, who looks at those kind of studies, who's called upon as part of the team that you talked about,

would that kind of cancer and growth of cancer be at least consistent with a primary lung cancer?
A Absolutely. I mean, lung cancer could do that, sure.
Q All right. Now, one of the other things you told the jury was that you were looking through the films with them again on that January 16th CT scan of the chest, and you said that you thought that there were more than one mass in the lung. Remember?
A Right.
Q Now, are you prepared to tell the jury today that within a reasonable degree of medical probability, which is the test, do you believe there was more than one mass?
A Yes. I mean, we went through the lower lobe lesion in addition to the questions raised in the upper lobe lesion.
Q Doctor, you remember we had the chance to take your deposition, correct?
A Yes.
Q And, therefore, we know a little bit about what was said before, and your opinions, correct?
Let me just ask you if you remember these questions and your answers beginning on page 41 and going to 42:
"Question: Now, greater than 50 percent. Are you able to testify more likely than not there's more than one mass in the left upper lobe?"
Your answer is: "I'll have to defer. I think

there's a good possibility there may be more than one lesion. You may live in a world of legal probabilities. I practice on a daily basis in the manner that I'm interfacing with you now, right? And we suggest and we raise possibilities. I can only speak to the way I was trained and the way I practice. There is a reasonable possibility this could be two adjacent lesions.
"Question: Are you able to state more likely than not there's more than one mass? If the answer is yes, fine. If the answer is no, we'll live with that."
Once again this is your answer: "I have to suggest there's a possibility. I don't know how much clearer I can be."
And then the question: "Are you able to quantify it? Are you able to say, no, I can't quantify anything with a great" -- and then the question -- "with a greater than 50 percent likelihood there's more than one, or you just

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don't know?
"Answer: I just don't know."
Do you remember those questions and your answer concerning whether or not there is one mass or not?
A Yes, I do.
Q Okay. Doctor --
A But we were talking about the upper lobe, weren't we?
MR. REILLY: Your Honor, that's the problem.

THE COURT: Just a moment. Overruled.
Go ahead with your question.
Overruled. You can go back into this on redirect if you need to.
Go ahead.

BY MR. COHEN:

Q Doctor, with respect to the lesions that you were showing the jury concerning the lung, you talked about a little bit about spread. And that means metastasis, what cancer does, and how it spreads and grows throughout the body and organs and structures, correct?
A Yes.
Q All right. Can cancer in the lung spread to itself?
A Yes, it can.
Q It is not -- it is within a reasonable degree of medical probability that you know, radiographically speaking, as a radiologist that even if you have a lung lesion, that lung lesion can not only spread to other structures outside the lung but within itself?
A You mean to the lung? Yes, that's true.
Q And that could still be characteristics of a primary lung cancer?
A Yes.
Q Okay. You talked a little bit about the CT of the abdomen, and you spent some time with the jury concerning the

wedge-like defect. Just so that there's no misunderstanding, and I think you were clear, that wedge-like defect has nothing to do with cancer?
A That's correct. That was only our marker so you always knew that you were looking at the same slice in the kidney. It was just fortuitous that that slice or the abnormality was on the same infarct. So we can always look at the infarct and go, we're there.
Q With respect to -- with respect to the MR that was done by Dr. Morillo -- and we covered it briefly before -- do you know as you sit here today whether or not Bob Allen's treating cancer doctor, Dr. Sridhar, actually reviewed that MR of the kidneys and the abdomen and the liver himself? Do you know if he did or not?
A No, I would not know.
Q You talked a little bit about one of your recommendations would be a six-month follow-up if you would see something in the kidney that would cause concern, correct?
A No.
Q I'm sorry. Not a six-month. You had asked for a follow-up sooner, correct?
A Right, I would --
Q All right. Did you know that in January of 1999, when Bob Allen was diagnosed with cancer, that he was told he was

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in a terminal condition, that he was going to die?
A No, I didn't.
Q Did you know that when you looked at the films blindly, that he died within approximately eight, eight and a half months from the time of diagnosis to the time of death? Did you know that?
A Can you rephrase the question?
Q Sure. When you looked at the films blindly, did you know that from the time of diagnosis to the time of his death was only about eight, eight and a half months?
A No, I did not.
Q Doctor, do you know, as a radiologist, about the progression of kidney cancer versus lung cancer and the deaths -- the death rate associated with lung cancer versus kidney cancers? Do you know at all that association?
MR. REILLY: Your Honor, this is well beyond the scope of the direct exam.
THE COURT: What the doctor does know and does not know within the realm of his expertise is -- is or may be relevant pertaining to his opinion. That is to say that Counsel can inquire into what he's not aware of or does not know, and that may or may not be important.
Overruled.
And, doctor, if you do not know you may say you do not, and that takes care of it.

Repeat the question for him.
MR. COHEN: Yes, sir.
BY MR. COHEN:
Q Doctor, do you know the relationship between the prognosis of kidney cancer and death rates versus the prognosis of lung cancer and death rates?
A I don't know.
Q You don't know whether or not patients with lung cancer --
THE COURT: He says he doesn't know. Ask your next question.
MR. COHEN: Thank you, sir.
BY MR. COHEN:
Q You talked about the January 16th CT scan, and then moved to the August 1999 scans, whether it be of the abdomen or of the chest, correct?
A Correct.
Q All right. But you looked at almost all of these scans that are in evidence, correct?
A I imagine so, yes.
Q I mean, you looked at a number of scans because they told you the story?
A Right. I was shown films, and I was told that they were all the radiology on Mr. Allen.
Q And what you noticed was that from the time of

January 16th, 1999, when the lesion in the lung was diagnosed, that lesion grew and spread consistently over time?
A Rephrase or repeat that question.
Q What you knew by looking at all the films in this case is that the lung lesion that was diagnosed in January of 1999, continued to grow and continued to spread in growth all the way through and including August of 1999?

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A Well, there's actually two questions there. The upper lobe thing did grow. We saw that all those things grew. And something was spreading. I'm not suggesting it was the lung that spread, but there was progressive spread of disease, there's no doubt. We're just . . .
Q At the very least, that continued growth would be consistent with a primary lung cancer?
A Absolutely, sure.
Q And if it spread to the mediastinum and the hilum, and if it spread to the lumbar region, and it spread to other bones in the body, that would be consistent with a primary lung lesion?
A Yes, it would.
Q In fact, Dr. Deprima, if you assume with me for purposes of this question that it was a primary lung cancer, then you know that could also spread, metastasize and grow to the kidney?

A Yes, it can.
Q So if it was -- assume with me for purposes of this question if it was a primary lung cancer, then that could account for the disease that you saw, the tumor that you saw in the kidney if it was a primary lung?
A Assuming that we see the single kidney cancer?
Q Yes, sir.
A Or the kidney lesion? Yeah, that's possible.
Q Because you at least agree that the first time you saw that kidney lesion it could have been cyst like?
A It could have been, but it turned out not to be. We looked at all the films.
Q On January 16th, 1999, you could not call that kidney lesion solid?
A Based on that single study? Yes, sir, that's true.
Q Doctor -- and I don't have much more. After you've seen all the studies -- well, let me ask something before I get to that.
You talked a little bit about Interleukin 2. Remember Mr. Reilly at the end asked you those questions about some potential cancer-fighting drugs? You know -- do you know when Interleukin 2 was administered to Mr. Allen?
A No, I was asked to assume when it was, but I don't know for a fact.
Q Mr. Allen ended up dying no matter what treatment was

provided, correct?
A He did die.
Q Okay. Do you know what effect Interleukin 2 even has with respect to kidney cancers?
A I'm not even sure what you're asking.
Q Do you know whether or not Interleukin 2 is even effective in treating kidney cancers?
A As I said earlier, I'm not an oncologist, but my general understanding is that it is a therapy for renal cell.
Q Do you know that it's minimally effective?
A I wouldn't know that.
Q Do you know that in kidney cancers that they spontaneously regress?
A Any cancer can spontaneously regress, that's true.
Q So the lung cancer, the mediastinal spread, or the lung cancer that you saw in the chest of Mr. Allen sometime in August of or September of 1999, those last films that you

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looked at, that could have been a spontaneous regression, correct?
A Yes, it could.
Q Last area of question, doctor.
Doctor, are you able to state strictly from a radiological perspective that you were able to rule out a primary lung cancer based on all of the films that you've seen?

A By saying "rule out", I assume you to mean can I absolutely exclude that possibility? No, I can't exclude that. It could be.
Q Are you able to state conclusively that this is a primary kidney cancer?
A I thought radiographically that was the most likely diagnosis.
Q Are you able to state conclusively it's a primary renal cancer?
A No, that's not what radiology does.
Q And, doctor, last area of questions. The fact that it's solid -- that is, the lesion in the kidney -- does that enable you to state conclusively that it's a primary renal cancer?
MR. REILLY: Objection, Your Honor. That's not the standard.
THE COURT: Well, he's an expert witness, and the doctor may answer that. I'll permit him to answer as an expert.
Go ahead. If you know, you may. If you don't --
THE WITNESS: Solid lesions ups the ante that it could be a cancer. Is it absolute? No.
BY MR. COHEN:
Q And a solid renal mass could still be a primary lung cancer, correct?

A Yes.
MR. COHEN: Thanks, Dr. Deprima.
THE WITNESS: Thank you.
THE COURT: All right, redirect examination.
MR. REILLY: Thank you, Your Honor.

Redirect Examination

BY MR. REILLY:
Q Dr. Deprima, let me start with Mr. Cohen's use of your deposition on the left lower lobe question that he posed. You remember when he asked you whether or not, in your opinion, the left lower lobe represented a second lesion?
A Yes, I do.
Q What he read to you from your deposition was a discussion of whether or not the tumor in the left upper lobe was one or two lesions, wasn't it?
A Yes, thank you for clarifying that.
Q Had nothing to do with whether or not you thought that the left lower lobe was another tumor in his lung, right?
A That's correct. I -- the left lower lobe was the one that we looked at and we drew, and it was there, and it got bigger. What that deposition business was about, as best as I can remember, was is whether we were walking through the slices the bread in the upper lobe was it just one or could there be a second smaller one right next to it. And that's what that discussion of visitor one or two is about.

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To me, radiographically, there's no question there's at least, at the minimum, an upper lobe mass and a lower lobe mass. And we were just discussing that upper lobe mass could there be more than one. And I was not absolutely sure to a degree of medical certainty.

Q Doctor, just because Dr. Messenger wasn't negligent when he didn't see and report the left lower lobe tumor, just because Dr. Messenger wasn't negligent when he didn't see and report the tumor on the kidney, that doesn't mean they weren't there, does it?

A That's correct. I mean, they are there.

Q Assume for me that Dr. Messenger has come into this courtroom, and he's acknowledged --

THE COURT: Let's don't ask him to comment on another witness' testimony. That's where we're getting into all this difficulty. You're asking him to assume that somebody testified in this courtroom to something. The jury heard all these people, and you can argue this to the jury. But asking him to comment on the other testimony, I don't want to get into that.

MR. REILLY: Fine, Your Honor.

BY MR. REILLY:

Q Just because Dr. Morillo wasn't negligent when he didn't report the mass on the kidney in the MRI doesn't mean it wasn't there, does it?

A That's correct. I mean, we've seen that they're there.

Q You've shown it to this jury?

A Right.

Q Mr. Cohen just asked you whether or not the spread of cancer as it appears radiographically on these films isn't consistent with a lung primary, it's also consistent with a kidney primary, isn't it?

A That's right.

Q And in your opinion, which is it more consistent with?

A Well, my opinion, I thought that the whole story with all the pictures and the single kidney lesion and the multiplicity elsewhere was more consistent with it started in the kidney and it spread to other parts.

Q Mr. Cohen asked you whether or not there couldn't be spontaneous regression of the tumor that you showed this jury that shrunk between August and September in the mediastinum, correct?

A Yes.

Q Do you know of any reason for spontaneous regression to occur at exactly the same time Mr. Allen received Interleukin 2?

A No, I don't.

MR. REILLY: No other questions, Your Honor.

THE COURT: Thank you, Dr. Deprima. You may step down. Thank you, sir.

All right, your next witness.

MR. REILLY: Your Honor, it's 4:00 o'clock. And as I indicated --

THE COURT: We quit early yesterday. We're quitting earlier and earlier and starting later and later. I don't know. Do you have -- you don't have a witness available at this point? I mean, I'm not saying that critically. Do you have a witness available?

MR. REILLY: No, Your Honor. All I have left are

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doctors, medical doctors. And they are scheduled to start on Monday. I didn't know exactly how long this would go.

THE COURT: Okay. Fine. That's fine.

All right. Then, ladies and gentlemen, we will let you go for the weekend.

We have been in trial for three weeks. You've been very, very patient and very cooperative with the Court and with Counsel, and we all appreciate that very much. We know that at times that some of the statistical data and otherwise have been a little slow or maybe even a little tedious, but you folks have stayed with it, and we do appreciate your attention. That's very important.

It's very important now, more than ever, as we're getting toward -- as we're moving along and hopefully getting toward the conclusion of the presentation of the evidence, that you not talk about the case with anyone or permit anyone

to talk to you about the case.

If there should be in the newspaper, radio television, don't read it, watch it or listen to it. And we will see you on Monday morning at 9:00 o'clock. We will commence with the testimony at 9:00 o'clock on Monday morning.

Thank you very much.

(The jury exits the courtroom.)

THE COURT: I have two things I want to bring up and go over with Counsel.

One is -- deals with the suggested or tentative or proposed jury instructions. The defense requested charges are numbered. The Plaintiff's are not, which is all right. But it will be a lot simpler when we get into the charge conference if we're all talking about the same document when we get into a discussion.

So first of all I would like -- and I can go through them and number mine. I don't have any trouble doing that, but then I'm going to be saying, well, I'm looking at number 12 and you all are counting pages. I know, because I go through this all the time in other charge conferences, particularly in my criminal cases where nothing is numbered.

So if we -- and I'm sure you can before Monday just number them. It's a very simple thing. I could do it myself, wouldn't even bother you with it, but then you all

need to have numbered copies also.

Secondly, some of the instructions are the same, obviously, because you get them from the same sources, the pattern jury instructions. So what I would like to have is I would appreciate it if somebody on one staff or the other -- doesn't matter to me whether the Plaintiffs do it or the Defendants do it, doesn't make a bit of difference. It has nothing to do with ruling on the merits of what is going to be instructed in the actual instruction itself.

What I would like for us to do is to put together a single document so we can all deal with taking those instructions which both of you submit and basically are the same, and designating so we don't have to waste time going through with and saying, okay, Plaintiff's Number 2 is the same as Defense Number 4 and all that. In other words, I would like for us when we finally get to the charge conference on Tuesday to be dealing with the differences between the two requested sets of instructions.

So it may be that somebody can put together something that maybe highlights a phrase or paragraph or

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something in one or the other so that we can focus on that. I'm not stating this very well, but what I'm trying to do is to get something that we can pick up and all deal with and say, okay, one, two, and three are all -- for example, are the same in both sets, and they're agreed to. So we can go

immediately to charge number four.

Number four, take the Plaintiff's charge number four. And there may be a paragraph here that the Defendants have objection to. Fine, highlight it in some way. Then we focus on that paragraph, we know and we turn to the Defendant, say, tell me your objection, what's your response, we rule on it and we turn to the next one.

I think it will help all of us, and it will save a lot of time in the charge conference if we can focus on what are the objections. And, indeed, there are some requested charges from the Defense that are not requested at all by the Plaintiffs, and to which the Plaintiffs may agree or may not agree or have objection to the whole thing.

So if we could get some sort of -- some sort of joint document or some sort of agreed document that reflects your objections -- and they can be broad, I don't care. I'm not asking you to stipulate to things that are anything like that. If you can, that's helpful, but if you can't, you can't.

What I would like to have is something that we can kind of focus on that we know that we go immediately to instruction number four and we got a problem with paragraph three. Then we go to five, we got a problem with the whole charge. Then we go to six and it's agreed upon, or whatever.

And I can do that, compare and put them back and

forth and all that, but I think maybe an hour or two of some of your efficient staff people working on this could come up with something that would help us save two or three hours of talking back and forth and trying to find the particular phrase or the particular paragraph that is a problem.

Mr. Reid?

MR. REID: We can do that. We'll call them and we'll get together and do that.

THE COURT: I think that -- you understand what I'm getting at.

MR. REID: Exactly.

THE COURT: And I don't want anybody to waive any objections or requested instructions you have or anything like that.

And then if we can come up with kind of one document, and everybody's working from the same document, I'm confident, drawing on my experience with the other 50 or so jury trials -- no, it's not that, it's about half that, it's about 28 jury trials that I have every year, that's the biggest waste of time we get to a charge conference is trying to figure out what it is that people do object to or don't. And so here I think that would be helpful.

The second thing I thought that we should resolve -- and I'm not clear whether it -- maybe it has been resolved -- was the problem about the chart that Dr. --

MR. CESARANO: Dr. Lacy Ford.

THE COURT: Thank you, sir. Dr. Ford.

MR. REID: We're working on a reply to their memo, and we'll get it to you.

MR. CESARANO: That may not be what he's talking

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about.
THE COURT: Something about we resolved something or other, and I wasn't sure whether it was that or something else. Tell me what it was.
MR. CESARANO: We have resolved the issue of the medical bills. And we've reached a stipulated figure to be presented to the jury for the amount of medical expenses.
THE COURT: Very good.
All right. With respect to this other matter, I'm just wondering. Well, there's a motion been filed, and we get a response.
MR. CESARANO: Excuse me, Your Honor.
THE COURT: We need to resolve that. When do you want to do that? You want to do that early Monday morning, or when do you want to do that?
MR. CESARANO: Are you talking now about the motion to strike the question and answer of Dr. Ford?
THE COURT: Yeah.
MR. CESARANO: Yes, you indicated there was no great rush. We will have a response prepared and turned in

Monday morning.
THE COURT: Well, when do we want to argue it is what I'm getting at. Because, as I say, these evidentiary days are getting shorter and shorter, and the -- you know, we might as well spend some of this time on the legal arguments.
Let me inquire as to where we are. I know that you all have indicated we would be finished by March 6th. But what -- where -- how are we progressing? Can somebody give me a guesstimate or approximation? Nobody will be held to this.
MR. REILLY: I understand.
Judge, you had asked me earlier whether we would be done by mid week, and we will be done by mid week.
THE COURT: Of next week. So that would -- you're looking at -- even with a charge conference on Tuesday afternoon, you think -- and I don't know how long that will take. But you believe that you would be through by perhaps Wednesday the 26th? Wednesday is the 26th.
MR. REILLY: Yes.
THE COURT: Approximately.
MR. REILLY: Yes.
THE COURT: All right. Does the Plaintiff know at this point in time whether or not they anticipate having some rebuttal testimony? And if so, approximately -- guessing again, estimating again -- not to be held to it, how long

that might take?
MR. GROSSMAN: An hour, two hours, something like that.
THE COURT: Pretty good guess. I can't quarrel with that. That's fine.
So we are looking, then, even with -- well, we're -- that helps in terms of what we do with the charge conference, because we can -- we can not be rushed in it, we can take our time with it.
So we're looking at finishing the case, then, approximately -- again, may not work that way, but approximately the next Wednesday, the 26th, or morning of the 27th. That would be good, because then we would be looking at closing argument on -- if this all works out as well as we hope it does, we would be looking at closing argument on the 27th, which would give the jury -- wouldn't put them under

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pressure of getting the case on a Friday afternoon late and having to work Saturday or whatever. All right. Well, that's good.

Is there anything else that anybody can think of that might be helpful that we need to resolve at this time?

MR. GROSSMAN: About 10 days ago I wrote out a stipulation for Mr. Reilly and team to agree to on that library book that's not available in Dade County. I have not heard a response yet.

MR. REILLY: We will give him one Monday, Your Honor. I promise. Sorry.

THE COURT: That's fine. Although I thought that you -- and then perhaps I read more into the question and answer that was directed to Mr.-- to Dr. Lacy Ford about the availability of that book. I thought he said he had never read it, and here is a man that's done a hundred thousand, 10,000 or 3000 hours of research on everything available.

I thought you had neatly tied that off with a neat little suture. Now, maybe I --

MR. GROSSMAN: I don't think we asked about that book, Judge. And, again, it's just one of those things.

THE COURT: I thought you asked about that book.

MR. GROSSMAN: No, we didn't.

THE COURT: You asked about some book, and I thought that -- I didn't know the name of the book. You asked about some book, and he said he had never read it or seen it, and that wasn't the book.

MR. GROSSMAN: No, sir.

THE COURT: All right.

MR. GROSSMAN: If I never see or hear from that book again I'll be very happy.

THE COURT: If he had said he had never seen it, then I thought --

MR. GROSSMAN: No, we didn't ask about that book.

THE COURT: Here we had this man who has read everything on the subject in the world.

MR. GROSSMAN: Right. He didn't bring it forward on his direct testimony, either, when he was doing his research with all the articles, and --

THE COURT: Thank goodness. Because it left out about 31 billion or million, 500,000, for which I'm grateful. Whatever he brought up, he brought up a plenty, a plethora of --

MR. REILLY: Next time, Your Honor.

I need my book back because my library card is going to expire.

THE COURT: And he surely can't afford that nickle a day. I'm sure they're going to charge for overcharge.

(Discussion held off the record.)

THE COURT: All right. Monday morning, 9:00 o'clock.

Oh, maybe we can take this matter up and get it resolved. Of course, I guess we're moving along well enough.

MR. REID: Monday afternoon?

THE COURT: All right. Okay. Monday morning, 9:00 o'clock.

(The evening recess was taken. Court to reconvene on Monday, February 24th, at 9:00 a.m.)

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I N D E X

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* * * * *

CERTIFICATE

I, Stephen W. Franklin, Registered Merit Reporter, and Certified Realtime Reporter, certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

Dated this 21st day of FEBRUARY, 2003.

_____

Stephen W. Franklin, RMR, CRR

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